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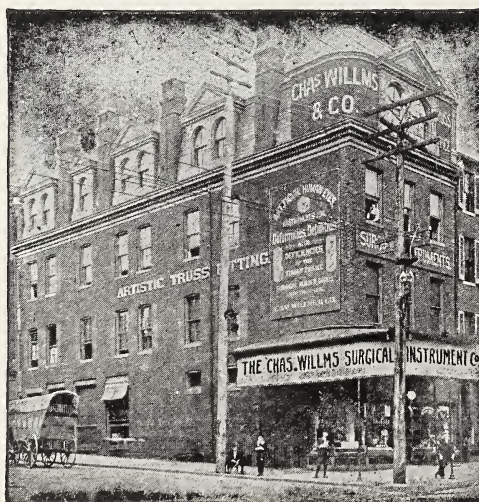
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MARYLAND MEDICAL JOURNAL

A Weekly Journal of Medicine and Surgery.

VOL. XXXVI.—No. 3. BALTIMORE, OCTOBER 31, 1896. WHOLE No. 814

Original Articles.

THE IMPORTANCE OF LABORATORY METHODS IN DIAGNOSIS.

By Charles E. Simon, M. D.,
Baltimore.

THIRD PAPER.

The examination of the expectoration for tubercle bacilli and elastic tissue.—It is a mournful fact that there are men who are entitled by the law to practice medicine who not only maintain that an examination of the sputum for tubercle bacilli is unnecessary in the diagnosis of pulmonary tuberculosis, but who even venture to assert that the so-called tubercle bacillus has nothing whatsoever to do with the production of tuberculosis.

The writer has before him a letter in which a person who professes to be a physician writes as follows :

"Tuberculosis if produced by a germ at all is produced by a life-given germ, not an organized germ as the bacillus. It is a law of nature that living matter produces other living matter of the same kind, governed by the same laws and endowed with the same capabilities. That the cause should be a certain bacillus is false, for it must of necessity produce another bacillus of the same kind. I have made microscopical examinations of the various sputa, taken from cases affected with tubercular, caseous, fibroid and miliary and in all such cases the sputa had a lifeless appearance, as viscous, and in the most cases the excretion of the bowels showed nothing but a defect of proper nourishing the system."

The laws of Maryland actually allow such a person to practice medicine! The only difference between a man of this kind and an Indian medicine man, or a gypsy hag, is that the one possesses a microscope and the other not. True, it is not altogether clear through which end of the instrument this scientific investigator looked. Were some such progressive newspaper as the *Baltimore Evening News* to start a crusade against "physicians" of this caliber, it would probably accomplish more direct good than by its investigations of policy joints and the like.

It is not customary to send circulars of information to every physician in the world, whenever a new truth in medicine has been elicited by carefully conducted investigations, but it evidently is the duty of every physician to familiarize himself with such facts.

Were a physician to mistake the pregnant uterus for a fibroid tumor and proceed to its removal a suit for malpractice would undoubtedly follow and end his career. The public has the right to demand from the physician of today an early diagnosis of pulmonary tuberculosis, and the writer strongly questions the propriety of shielding the blunders of his colleague who has treated an early case of phthisis with post-nasal applications and the cautery.

When a patient who has wasted away to a skeleton comes to the physician complaining of cough, expectoration, fever and night sweats and when a physical examination reveals the existence of cavities as large as an orange, a special examination of the sputum for tubercle bacilli will not be necessary to establish the diagnosis. In the early stages, however, when the loss of flesh is as yet but trivial, when the physical signs are indefinite, and the expectoration scanty, an examination of the sputum is absolutely necessary and cannot be dispensed with.

Physicians should remember that an early diagnosis of pulmonary tuberculosis is of vital importance, as successful treatment depends upon the measures taken before the lung is extensively diseased. The person who claims that he is able to diagnose pulmonary tuberculosis in every instance without an examination of the sputum betrays unjustifiable ignorance, and the person who shields a man of this kind as a matter of professional etiquette does not deserve the name of an honorable physician. To stand by "professional etiquette" is here ridiculous.

By neglecting examinations of the sputum the physician not only injures his patient, but actually places in danger the lives of the persons with whom the patient comes in contact. The infectious nature of pulmonary tuberculosis is an established fact.

Technique.—If the sputum from a case of well-advanced pulmonary tuberculosis be examined with the naked eye, upon a dark background, such as a piece of ordinary window glass, placed upon a black paper, tiny little cheesy particles will usually be observed presenting a yellowish-white color.

Experience has shown that these particles are particularly rich in tubercle bacilli, and attention should be directed to their presence, whenever a sputum is to be examined for the organism in question. When found, a fragment is placed upon a coverslip and spread out in as thin a layer as possible with the aid of a platinum needle, or by pressure between two coverglasses.

The specimens are then allowed to dry in the open air and fixed by passing the coverglass, held with a pair of forceps, three times through the flame of a Bunsen burner or a spirit lamp.

Very frequently, however, and particularly so in early cases of phthisis, no such cheesy particles are found. In that case the sputum should be thoroughly agitated and a drop spread out upon a coverglass in as thin a layer as possible. The specimen is allowed to dry and is fixed as described. Among the numerous methods which may be employed for the purpose of staining the tubercle bacilli, that of Ziehl-Neelson is perhaps the most convenient.

The solution consists of 90 c. c. of a concentrated alcoholic solution of fuchsin. A few drops of this solution, which may be kept almost indefinitely, are placed upon the coverglass specimen, held with forceps, and heated over a small flame until ebullition occurs. The specimen is then immediately rinsed in a five per cent. solution of sulphuric acid, whereby all bacteria with the exception of the tubercle bacilli are decolorized. The excess of acid is washed off with water and the specimen dried with filter paper. It is then mounted in a drop of Canada balsam, cedar oil, or water, and is ready for examination.

The search for tubercle bacilli may be further facilitated by employing a contrast stain. To this end the specimen, before mounting, is stained for one minute with a few drops of a saturated aqueous solution of methylene-blue; the excess of stain is removed by washing with water, when the specimen is dried and mounted as described. The whole procedure of staining may be further abbreviated by employing Gabett's method. The specimen is here first stained with the carbol-fuchsin solution and immediately transferred to a solution containing 1 to 2 grammes of methylene blue in 100 grammes of a 25 per cent. solution of sulphuric acid. It is then washed with water, dried and mounted.

A $\frac{1}{12}$ oil immersion lens is most convenient in the examination of specimens, but, as has been pointed out before, a $\frac{1}{6}$ is sufficient.

If tubercle bacilli be present, they will appear as elongated, slightly curved rods, sometimes presenting a beaded appearance. They are stained red by the carbol-fuchsin, and can thus be distinguished without difficulty from all other bacteria that may be present. If the counterstain with methylene-blue has not been employed all other elements in the specimen will be colorless, while all with the exception of the tubercle bacilli, which are stained red, will appear blue if the double stain has been used.

If tubercle bacilli be found the diagnosis of course is clear at once. If not, other specimens should be prepared, and if a negative result be obtained even then, it will be advisable to make further examinations of the sputum from time to time. In doubtful cases the following procedure may be recommended: The bottle containing the sputum is kept for several days at a temperature of from 37° to 40° C. An ordinary drying oven answers the purpose admirably. About a tablespoonful of the sputum is mixed with two tablespoonfuls of water and treated with 8 to 10 drops of a 30 per cent. solution of caustic soda.

The mixture is boiled until a homogeneous consistence has been obtained. 5 to 10 tablespoonfuls of water are further added, when the mixture is again boiled for a few moments, and then placed in a conical glass for sedimentation. If a Daland's hematokrit be at hand, the required sediment may be obtained in a few minutes.

The supernatant fluid is poured off and the sediment examined as described. In this manner it is not infrequently possible to demonstrate the presence of tubercle bacilli, where all other methods have previously furnished negative results.

It should be remembered, however, that only a positive result is convincing, although tuberculosis may probably always be excluded, when notwithstanding most careful and repeated examinations, no tubercle bacilli are found. In every case where tuberculosis is known to exist, it is well also to examine the sputum for the presence of shreds of

elastic tissue. If found we may assume that ulcerative processes are going on in the lungs.

To this end the thick purulent portions of the sputum are placed upon an ordinary piece of window glass, blackened upon its lower surface and covered with a similar but somewhat smaller piece of glass, the sputum being thus spread out into a thin layer. With a little practice it is possible to thus discover particles of elastic tissue with the naked eye.

The beginner will frequently mistake particles of bread, collections of milk globules and fragments of epithelium coming from the tongue, for elastic tissue. It is hence advisable to pick out the suspicious looking particles and to examine them under the microscope.

A little practice in this technique will render examinations of sputum an easy matter for any physician who understands the use of the microscope.

It is needless to say that the bottles or plates containing the sputum should be thoroughly disinfected in a shallow dish containing a 1 to 500 solution of bichloride of mercury as soon as possible, so as to prevent the drying and the dissemination of tubercle bacilli through the air. Negligence in this respect may lead to disastrous results.

The most convenient receptacles for sputa are the so-called sanitary cuspidors, made of paper, which may now be obtained from most instrument makers and first-class druggists. Glass and porcelain vessels should be subjected to the action of boiling water for at least one hour.

Since writing the above the Health Department of the City of Baltimore, through the intervention of the committee on public sanitation of the Baltimore Reform League and the MARYLAND MEDICAL JOURNAL, has been provided with a bacteriological laboratory at which the physicians of the city may have the sputa of their patients examined for tubercle bacilli, free of expense. It is to be hoped that physicians who are themselves unable to make the necessary examination will freely avail themselves of the opportunities thus offered.

A CASE OF PROTRACTED LABOR.

READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY, OCTOBER 13, 1896.

By J. N. Upshur, M. D.,

Professor of Practice of Medicine, Medical College of Virginia.

MRS. H., aged 40, of good health prior to two months before delivery, when she had an attack of dysentery. I saw her at that time. She had a recurrence of the attack twice, but treated herself with the same remedies prescribed by me during the first attack. With this exception, her pregnancy had been an uneventful one.

Labor came on suddenly at 7 P. M., September 11—pains so active and strong that I was twice sent for within an hour. When I reached my patient at 8 P. M., she looked pallid and showed evidence of extreme suffering—pains were strong and regular, coming on every few minutes. Digital examination revealed a cervix *very rigid*, thick and about two inches long, through which could be felt the vertex presenting in the first position. The pains, though violent and causing much suffering, made little impression in dilating the rigid cervix. To procure rest and relaxation of the cervix, about 12 P. M. I administered a hypodermic of sulphate of morphia, grain one-fourth, sulphate of atropia, grain $\frac{1}{150}$. This procured her some respite from suffering for three hours, when pains again became active. Cervix had slightly softened. She was now given chloroform, but only with the effect of stopping pains. A second hypodermic was given at 7 A. M. and I left the patient for three hours.

On my return at 11 A. M., I found cervix relaxed and dilatable and pains active and regular. Patient looked pallid, with feeble pulse, and had clammy skin. But that she had had three exhaustive attacks of bowel trouble and a wearing labor from the beginning; I should have suspected concealed hemorrhage. Chloroform was again administered and she was normally delivered at 12.45 of a still-born male infant weighing nine pounds. She had last felt the

motion of the child just prior to the onset of labor. There was delay in the delivery of the placenta and the uterus was in a state of complete inertia. Examination showed the placenta detached and it was easily removed; introduction of the hand being followed on delivery by a double handful of coagula. It was evident that partial detachment of the placenta had taken place prior to the birth of the child.

The uterus remaining obstinately relaxed, the hand was passed into the cavity, which presented a feeling of a ragged bag, while on the right of the uterine wall, half way between its anterior and lateral portion, could be felt an incomplete rupture of the uterine wall in its long diameter about three inches long and extending four-fifths of the thickness of the uterine wall, so that a narrow escape had been made from opening the peritoneal cavity. After administration of sulphate of strychnia, grain $\frac{1}{20}$, and fluid extract of ergot (Squibb's) 5v, with introduction of ice into the cavity, the womb was induced to contract finely. I would have preferred a hot salt solution, but it was not available and only a septic syringe with which to use it, if it had been. The patient reacted well. Having always had a free secretion of milk, tincture of camphor was ordered applied to the breasts, beginning a few hours after delivery, extending its application well into the axillae. This proved efficient and no milk was secreted.

On the second and third days after delivery the temperature only rose to 99.4° F. On the fourth day it reached 100° F. Lochia profuse, offensive, of the color of dirty dish water. Free hot douche of hot water and borax was ordered thrice daily.

But on the morning of the fifth day, finding no improvement except temper-

ature slightly subnormal (98° F.), the uterus was washed out freely with hot salt solution. Uterus was found above the pubis, and spongy. Ordered tincture of iron, ergot and nux vomica in full doses every four hours.

On the sixth day I found little change in lochia and that seventeen napkins had been used in previous twenty-four hours; pulse fair at 90 to 100; temperature as on day before. Curette (sharp) was used and a number of dirty shreds of sloughing tissue were removed.

On the seventh day, patient expressed herself as feeling better; pulse and temperature same as on day previous. Curette was again used and large pieces of sloughing tissue were removed; curette gave way suddenly, giving sensation of entering a cavity, and was followed by a discharge of an ounce or more of thick, dirty-colored, stinking pus. I believe the rupture had healed on the surface and an abscess had developed at bottom. The curette was freely used until discharge was slightly stained with blood. Half gallon of salt solution was run through the uterine cavity till it came away clean and odorless; patient expressed herself as feeling much more comfortable.

On the eighth day, pulse and temperature same; ten napkins used; curette applied; no shreds. Washed out with peroxide of hydrogen, followed by salt solution, and lightly packed with iodoform gauze.

Twenty-four hours after delivery the patient complained of severe headache, located chiefly in the occiput. This was relieved by two doses of phenacetine of gr. v. each, but returned when the drug wore off. Subsequently benefited by sodii bromidi gr. xx, and caffeine gr. ss. Patient had a comfortable night, has some appetite, expressed herself as free of headache and feeling much better; said headache returned after treatment of womb. She has taken on two days full doses of quinine, but I could detect no benefit from its exhibition. Bowels have been moved on alternate days by exhibition of compound senna powder. Tongue has been clean but pallid from beginning.

On ninth day, eleven napkins in last twenty-four hours; temperature, 100° F.; pulse, 108; had a good night, but sweated freely; appetite fair; discharge very little offensive; curette used; $\bar{3}$ j of pus discharged from uterine cavity; came from site of rupture; uterus reduced decidedly in size; washed out freely with peroxide of hydrogen, one-fourth to three-fourths hot water, followed by salt solution. Patient complained of violent frontal headache during the dressing, which passed off when completed; light packing of iodoform gauze applied.

Tenth day, eight napkins; pulse, 100; temperature, 99.4°; no odor in discharge; on removing gauze, $\bar{3}$ ss pus flowed away; uterus cannot be felt above pubis; measured three inches with probe; swabbed out with pure peroxide and replaced with gauze; complained of severe frontal headache during the dressing, which subsided when it was completed.

Eleventh day, five napkins; temperature, 99.2°; pulse, 100; on removing gauze, $\bar{3}$ ss pus; no sweating.

Thirteenth day, temperature, 99.4°; pulse, 100; no sweating.

Fourteenth day, pulse, 96; temperature, 99° F.; no flow.

Sixteenth day, pulse, 100; temperature, 99.5°; convalescence established; patient sat up an hour and a quarter.

Twenty-eighth day, patient dressed and moving about her room; says she is absolutely comfortable; no pain or weakness in back or elsewhere, except a little unsteady on her feet.

Remarks.—The above case presents first in interest, the *condition of the cervix* at the beginning of labor, so *hard and resistant* as to give the impression of previous disease, which had not been the case, except a slight cervical catarrh, for which I had treated her prior to her sixth confinement, which had been rapid and uneventful. Pains seemed absolutely inefficient in producing dilatations until after the administration of morphine—the resistance in spite of such strong contractions being responsible for the subsequent complications. I am sure that the patient's

pallor was due to concealed hemorrhage from premature partial separation of the placenta, not appreciated at the time because of my knowledge of three attacks of dysentery in the previous two months and the suffering she had borne incident to the violent uterine action, ineffective and depressant. The inertia of the womb was simply due to muscular tire.

The rupture of the uterine wall in its long axis is of interest, because the almost invariable rule is that when rupture occurs, it is in the transverse direction. "Boudl reported nineteen cases in 40,614 labors occurring in nine years in the Lying-in Hospital in Vienna. Jolly, in Paris, found 230 cases in 782,741, excluding from his list lacerations of the cervix. Harris estimates one case in 4,000 labors. Lusk found forty-seven deaths from this cause in New York between 1867 and 1875, inclusive, or one death in six thousand labors."—(*Lusk's Obstetrics*, page 603.) I had a case of complete rupture due to an after-coming hydrocephalic head—patient dying five hours after delivery.

Hagenberger estimates the mortality at 95 per cent.; C. Braun at 89 per cent.

(*Lusk*, page 603). The above facts show how rare is this complication, even though incomplete.

Another point of interest is the prevention absolutely of the milk formation by the early and repeated use of tincture of camphor in a woman who had in six previous confinements had an abundance. A long experience has proven no remedy better than camphor in my hands. The fact that only twice did the temperature reach 100° F. in a uterus so septic as I have described is remarkable and the efficient action in the direction of cure of free curettage, douching with salt solution and application of hydrogen dioxide in stopping suppuration, evidences the great value of this therapeutic method. The violent reflex headache coming on during the dressing and disappearing when it was completed is of interest, and shows plainly that the violent headache coming on twenty-four hours after labor was also reflex in character.

I deem myself most fortunate to have had such a satisfactory result in this case and place it on record for the instruction and encouragement of my professional brethren.

DISEASES OF THE RECTUM AND ANUS.

READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY, OCTOBER 13, 1896.

By George K. Sims, M. D.,

Adjunct Professor of Clinical Surgery, University College of Medicine, Richmond, Va.

FORMERLY this class of diseases received but little attention by the profession; consequently quacks fell heir to a great many of them. In recent years they have received more attention, but the majority of the profession do not give them as much attention as they merit. There is no class of diseases that cause more annoyance and suffering, or that patients will be more grateful for curing them, or more willing to pay for. Time will permit me to give only a general outline of the most important of them tonight.

A careful physical examination should be made in every case. The dorsal is

the best position for external inspection and eversion of the anal margin; for parts higher up and for operation, the knee-chest and the lateral or Sims' position is better. A female should always be placed in the Sims' position, for obvious reasons.

In making the examination, the tissues surrounding the anus should first be carefully inspected; after this, the interior of the rectum must be examined. This can be done either with the finger or the speculum, or both. A digital examination will be more agreeable to the patient if the finger is well lubricated and introduced gently. The

best lubricant for the finger that I have used is ordinary toilet soap; it fills the cracks around and under the nail and prevents the fecal matter from sticking. This can be easily washed out and you get rid of the bad odor, which is a very important consideration. If there is much soreness about the parts, carbolyzed vaseline will be much more agreeable to the patient.

In introducing the finger, notice the amount of resistance offered by the sphincters. The internal is an involuntary and the external is a voluntary muscle; they are separated by a well marked interspace. A firmly contracted sphincter is met with in cases of fissure ani; a loosely contracted one may be due to atony or paralysis, induced by repeated stretching by a polypus, hemorrhoids, or prolapsus. After passing the sphincter, the finger enters a large cavity called the rectal pouch, which is apparently without shape or form; if empty, the anterior and posterior walls are in contact. A great aid to digital examination is to fill the rectum with air or water, introduced by an ordinary bulb syringe. This puts the wall of the rectum on the stretch, so that any diseased condition can more easily be detected. After the digital examination, it may be necessary, for purposes of diagnosis or treatment, to introduce the speculum; in many cases, it will be necessary to give an anesthetic to do this, or even to insert the finger.

1. *Hemorrhoids.*—The first subject I wish to review is hemorrhoids. Of these, there are two varieties—external and internal—depending on their relation to the sphincter. External piles are venous or cutaneous. Of the former there are two kinds; first, a varicose condition of the external hemorrhoidal veins; this is very common and usually requires no treatment; the second is the thrombic pile, due to a thrombus in the external hemorrhoidal veins. A thrombic pile is tense, hard and very painful; it usually comes on suddenly and the bluish appearance of the thrombus can often be seen. The treatment may be palliative, which consists in keeping the stools very soft by laxatives and enemas

and the local application of soothing lotions or unguents, such as lead and opium wash, fluid hydrastis or hamamelis and lead water; or unguents of belladonna, opium, etc., followed by warm fomentations. If the size of the tumor or the pain seem to justify it, immediate relief may be given by incising the pile and turning out the clot—then applying a pad of antiseptic gauze and firm pressure by a "T" bandage to prevent the cavity from refilling.

Of cutaneous piles, authors recognize three varieties: First. Redundant cutaneous piles. These are common in persons having internal piles and are said to be diagnostic of that condition, with weakening of the internal sphincter. The second form is the hyperplastic pile; this is due to a hyperplasia of the connective tissue, from abrasions, fissure or ulceration. It is most often seen at the posterior border of the anus in connection with fissure ani—in fact, it is pathognomic of that disease. The third form is a hypertrophy of the normal radiating folds of the anus, the result of eczematous inflammation. The treatment of these conditions consists in removing the cause; then, if necessary, a portion of the redundant tissue may be excised and treated antiseptically. External piles should never be injected, as it can do no good and causes unnecessary torture.

Internal hemorrhoids are vascular tumors composed of dilated veins, capillaries and small arterioles. Ordinarily, they lie just within the anal opening, but they may extend as high as two inches from the anus; they may be single or multiple. They are caused by an increase of blood pressure about the rectum with obstruction to the return circulation, arising from diseases of the heart, lungs, or liver, enlarged prostate, stricture of the urethra, stone in the bladder, phimosis, cancer, or stricture of the rectum and chronic constipation. Symptoms—a feeling of weight, itching, tenesmus and pain, which may radiate to the genital or other pelvic organs. At first these are slight, but they gradually grow worse. The piles begin to protrude when at stool; later, a portion

of the mucous membrane may prolapse. If they are not replaced, the contraction of the sphincter muscle will cause them to become swollen and congested and gangrene may result. Rupture of the thin mucous membrane covering them causes hemorrhage—this may be very slight, or be several ounces. The blood is much redder than blood which escapes higher up than the rectum. The bleeding often relieves the pain and local symptoms for a time; but if it occurs frequently, as it often does, may cause serious anemia. In long-standing cases the sphincter becomes so relaxed that it allows the protrusion of the piles to exist almost constantly.

The diagnosis, when they are protruding, is simple enough; but when they are not filled with blood, your finger may scarcely feel them. In that case, after emptying the rectum with an enema, make the patient bear down as if at stool; at the same time, draw the anus open with your fingers. They may now be seen or felt, as they become distended. The smooth folds of mucous membrane of prolapse will hardly be mistaken for piles, as they lack the bunched appearance and the purplish color.

Rectal polypus, when protruding, is harder than piles or prolapse and has a distinct pedicle.

Treatment.—The majority of cases can be made very comfortable, if taken in time, by palliative measures; they consist in keeping the bowels open by diet, exercise, salines, laxatives and enemas. Try to remove the cause by appropriate treatment. Locally use astringent injections and unguents; these should be pushed well up into the rectum. When these measures fail to give relief, a more radical treatment becomes necessary. Moderately severe cases may at times be cured by dilatation of the sphincter, by means of the two thumbs. This requires an anesthetic, and must be done thoroughly. When the patient cannot take chloroform, or remain in bed for a few days, a cure may be effected by injecting a few drops of carbolic acid into the center of each pile, treating only one at a time.

This is tedious and uncertain at best, and not to be recommended. A better method of treating such cases is the one described by Dr. Earle of Baltimore; this consists in injecting cocaine, applying a clamp, cutting off the pile, and stitching the edges together with a continuous suture of catgut. By treating only one pile at a time by this method, the patient need not lose any time from business.

When, however, the piles are large and numerous, they had better be all removed at one sitting, by one of the standard operations, which are the clamp and cautery, ligation, and Whitehead's. Of the three, the clamp and cautery is the one most generally used, being, at the same time, simple, safe and effective. I will not enter into the details of these operations, but will mention a few practical points in the management. The patient should have a brisk cathartic two days before, and an enema the day before, and on the day of operation. The sphincter should be well stretched and temporarily paralyzed at the time of operation. No packing is necessary afterwards except a good external pad and a "T" bandage.

The bowels can be moved on the third or fourth day with salines or enemata. The patient must be kept in bed five or six days, and in a week can be discharged.

2. *Anal fistulas* may be complete or incomplete—the latter are external and internal. They result from a peri-rectal or an ischio-rectal abscess, which was not opened early enough to prevent the formation of an orifice in the bowel. The sinus is prevented from healing by the passage of fecal matter and gases, which keep up the irritation. The fistulous track is usually tortuous, and there are frequently blind sinuses leading off from it into the cellular tissues surrounding the rectum. Sometimes it goes around the bowel and comes out on the opposite side, forming a horse shoe fistula. An internal sinus, if left to nature, will sooner or later make an opening on the skin; but it may burrow into the ischio-rectal fossa a long time before it does so.

The *diagnosis* is easily made when the external or internal opening is found, but it is often difficult to find the internal opening. It will usually be found within the grasp of the internal sphincter—occasionally higher up. The sinus may extend above the internal opening, and rarely a second opening is present. If the probe, carefully passed into the sinus, fails to find the internal opening, inject some hydrogen dioxide into it; it will frequently find its way through and can be seen foaming in the rectum. It must be remembered that a sinus opening far down the thigh may lead to the rectum. On the other hand, we should not forget that a sinus in the neighborhood of the anus may be due to caries of the tuberosity of the ischium or coccyx, or even hip-joint disease, and have no connection with the rectum. In incomplete fistulae, there is an intermittent discharge of pus from the anus, especially when pressure is made upon the circum-anal integument.

Treatment.—Injecting the fistula with stimulating solutions is usually unavailing. An operation is almost always necessary to make a cure. Fistulae resulting from stricture of malignant disease of the rectum should not be operated upon unless the primary cause can be removed. All abscesses in this region should be opened early, curetted and treated antiseptically; this can often be done at the office, under cocaine. A very good method of treating many cases is the elastic ligature; draw it tight, and allow the patient to go about his business. The pain is quite severe for the first day or two. In three to seven days the ligature will cut through, and while it is cutting, the tract is beginning to granulate behind it, so that when it has cut through, two-thirds of the tract will be healed. The rest of it will heal after a few applications of silver nitrate, and aristol, iodoform or loretin. The ideal treatment is to incise all the structures between the two openings on a grooved director, also lay open any communicating sinuses; the fistulous tract should then be scraped out with a curette, or dissected out, washed out with a 1 to 3000 bichloride

solution, and the walls brought together by catgut sutures. Aristol or loretin should then be applied and the bowel confined four or five days. In incomplete internal fistulae, find the orifice, then pass a grooved director from within against the skin, making an opening here, then incise all the structures and proceed as in the complete fistulae. When it is impossible to clean out the fistulous tract thoroughly, they should be washed out with hydrogen dioxide, then kept packed with iodoform gauze to make them heal up from the bottom. The rectum should be washed out with an antiseptic solution after every evacuation and fresh gauze packing applied.

3. *Anal fissure* is a linear ulcer situated just within the verge of the anus. It results from a tear or excoriation in the mucous membrane of the sphincter, caused by hardened feces, syphilis, or the irritating discharges of diarrhea or dysentery. It fails to heal because of the frequent irritation by fecal matter, and the motion and spasm of the sphincter.

The *symptoms* of anal fissure are remarkable for the severity of the pain, which is intense, notwithstanding the insignificance of the lesion. It comes on during defecation, and may last for many hours. The manner in which it is reflected may cause the patient to attribute his suffering to disease of the bladder, urethra, or other pelvic organs. The dread of the intense pain causes the patient to refrain from emptying the rectum, and constipation results. Spasm of the sphincter muscle is the cause of this agonizing pain, and is always present in true and anal fissure. It is often so great that it is impossible to pass the finger into the rectum, or to make a satisfactory examination, without an anesthetic.

Treatment.—In recent cases, a cure can often be effected by keeping the feces soft by laxatives and enemata, washing out the rectum with carbolic acid or other antiseptic solution after each evacuation, the application of silver nitrate, and some antiseptic powder or unguent to the ulcer. When this treatment fails, as it often will in chronic

cases, the next best treatment is to thoroughly paralyze the sphincter by stretching it with the thumbs. Complete anesthesia is required for this operation. Another method, said to be more effectual than dilatation, is to make an incision through the base of the ulcer, dividing either the whole or a portion of the sphincter. Any small tab of mucous membrane or polypoid growth complicating the fissure should be removed at the time of operation.

4. *Prolapse of the rectum* may be partial when the mucous membrane only protrudes, or complete when all its coats are involved, the rectum being turned inside out. The disease is most common in children and the aged, from a weakened condition of the tissues. Anything that causes abnormal straining and bearing down—as stone in the bladder, urethral stricture, polypus, dysentery, chronic constipation, or phimosis—may be the exciting cause.

The *diagnosis* is usually very simple; the prolapsed tissues appear at first only when at stool, but frequent repetition of the process soon weakens the sphincter so that the prolapse occurs whenever the patient walks or assumes the erect posture. If allowed to remain out long, the tissues become so much swollen that it is difficult to reduce, and strangulation and gangrene may result.

Treatment.—The prolapsed tissues must be reduced by gentle, though firm, pressure with the fingers, using some lubricant on the parts. During the reduction the patient should assume the knee-chest or the lateral (Sims') position. If these measures fail, cover the finger with a piece of lint and insert it into the orifice of the protruded bowel and push it in slowly and gently. After it is reduced the finger is withdrawn and subsequently the lint is pulled out. The rectum must be supplicated by a T bandage, or strips of adhesive plaster, applied so as to hold the nates close together to prevent recurrence. The bowels must be kept soft and any trouble that is likely to produce straining must be removed. The patient should lie on the side or back or stand while evacuating the bowels. Astringent enemata,

ointments and suppositories are serviceable.

Under such a line of treatment, cases occurring in children and cases of moderate severity in adults can be cured. The more serious cases require surgical treatment. With a thermo-cautery make several longitudinal applications to the prolapsed tissues. Another method is to clamp longitudinal portions of the mucous membrane, which is then cut off and the stump seared with a red hot cautery iron. In chronic cases in which the sphincter has become relaxed, the triangular portion of the sphincter and also a portion of the posterior wall of the rectum may be removed; sutures are then applied so as to bring the divided walls together.

Ulceration of the rectum may be dysenteric, syphilitic, tuberculous, or malignant. The exciting cause is often constipation. It is most common among the aged and is often mistaken for dysentery. Symptoms: Irregular diarrhea, pain, tenesmus, muco-purulent and blood-stained discharges and other symptoms of dysentery. Ulceration in the upper part of the rectum is far less painful than in the lower part, within the grasp of the sphincter.

Treatment.—Keep the excreta soft, wash out the rectum after each stool and use mild, astringent, antiseptic and anodyne enemata and suppositories. A weak carbolio acid solution is very soothing and healing. An enema of laudanum in starch water will relieve the pain. Tubercular ulcers require iodoform and syphilitic cases require the iodides and mercury in addition to the local treatment.

PREGNANCY UNDER DIFFICULTIES.—Chavannaz (*British Medical Journal*) found in making a post-mortem examination of the body of a woman, aged 60, who had been operated upon for intestinal epithelioma, that the right Fallopian tube and ovary were absent, and that the uterus was retroflexed and bent slightly to the left. The patient had had three children (sex not stated), and her menses, which disappeared at the age of 50, had always been regular.

Society Reports.

RICHMOND ACADEMY OF MEDICINE AND SURGERY.

REGULAR MEETING HELD OCTOBER 13, 1896.

THE President, Dr. Landon B. Edwards, in the chair. Dr. Mark W. Peyser, Secretary and Reporter.

Dr. J. N. Upshur read a paper on A CASE OF PROTRACTED LABOR. (See page 40).

Dr. Paulus A. Irving thought it remarkable that there was no hemorrhage from the site of the uterine tear. Another striking feature of the case was the low temperature in spite of the large amount of pus dammed back—the more remarkable when we consider how a little excoriation or tear of the os or cervix is so often followed by a rise of temperature—sometimes even to 104° F. He commended Dr. Upshur for his most admirable treatment and successful issue, especially in the employment of hydrogen peroxide. Nothing could be added to it.

Dr. Lewis M. Cowardin called attention to the fact that hydrogen dioxide affected not only pus, but all organic fluids. Where a blood-clot was to be dissolved, he knew of nothing more efficacious.

Dr. J. S. Wellford thought hydrogen dioxide a better disinfecting agent than all others, because it produces super-oxidation of all effete matters, liberating in the body ozone. In employing it we imitate the processes of nature, changing the specific character of the ptomaines.

He asked Dr. Upshur the positions of the placenta and abscess in relation to the tear.

Dr. Arthur Jordan spoke of a case in which he had successfully used creatin, bichloride of mercury solution, hydrogen dioxide and hydrozone. Hydrogen dioxide had given better results than the first two, but pus was more diminished with two injections daily of hydrozone than three of hydrogen dioxide.

The President stated that in his practice a vaginal douche of hydrozone prevented the third day fever of the

puerperal state. His experience, with that of Dr. Irving, Dr. H. M. Taylor, Dr. Edward McGuire and others, in some cases of puerperal sepsis, had shown the great value of intra-uterine injections of hydrogen peroxide and hydrozone—simply keeping the os uteri well dilated so as to give free egress to the foaming pus, etc., that pours out. He uses a half-pint to a pint each injection—diluted or not with water.

Dr. Upshur, in closing the discussion, said the placenta was above and posterior to the rupture, the abscess being seated in the bottom of it. He has firm convictions with regard to the value of hydrogen dioxide. Often the efficiency of applications to the cervix, externally and canal, is lessened by a layer of mucus that cannot be wiped away by cotton. In cases of this kind, the dioxide on an applicator will dissolve the mucus, allowing the application to come in contact with the tissues. For cleansing purposes, he preferred a simple solution of hydrozone or hydrogen peroxide to the chemical agents, such as bichloride of mercury, carbolic acid, permanganate of potassium, etc.

Dr. G. K. Sims read a paper on DISEASES OF THE RECTUM AND ANUS. (See page 42).

The secretary reported a case of horse-shoe fistula successfully treated with hydrozone. Girl, aged 15 years. An abscess developed on either side and above the anus, which were on the point of rupturing. Both were incised and afterward injected with hydrozone until the discharges came away clear. The solution made its way from one opening to the other, demonstrating the presence of a horse-shoe fistula. In a week it was in a fair way to recovery.

Dr. Wm. H. Parker reported a case of LARGE HYDROCEPHALIC HEAD AT DELIVERY. Mrs. C., white, aged 30 years. Sixth pregnancy—overdue a fortnight. On September 10 labor began, becoming active on the 12th, delivery occurring normally on the 14th. The child was hydrocephalic and born dead. The head was nineteen inches in circumference, thirteen inches from ear to ear, fourteen from nose to occiput. All pre-

vious labors had been tedious, one lasting ten days. In April previous, a prolapsus of the uterus had been corrected, the hydrocephalic pregnancy occurring immediately afterward. There was no pelvic deformity.

Dr. Jordan prefaced a report by the following questions referring to hydrophobia.

First. Is there any more danger in the ordinary bite of a dog and that of one supposed to have been bitten previous to any manifestations on the part of the bitten dog?

Second. While one is in a state of doubt, what plan of treatment should be pursued, taking into consideration the moderate pecuniary circumstances of the patient?

He then related that a little dog had either received a blow or had been bitten on the left side of the head above the ear. There was nothing positive as to the cause of the injury.

Inquiry failed to reveal a supposed mad dog in the neighborhood. Two weeks passed and there was no manifestations of rabies. Then the dog bit a child, aged 18 months, that had been teasing it, on the back of the hand. The father immediately and thoroughly sucked the wound and cauterized it with carbolic acid. It progressed nicely, the swelling passed off and the wound got well with three separate and distinct scabs—one large, a second smaller, in which had formed a third, which now remains.

After biting the child the dog was sent away. Eight or nine days elapsed before any symptoms occurred in the dog and then it died after a series of not well defined spasms.

NEW YORK, October 8, 1896.

Dr. Arthur Jordan, M. D., Richmond, Va.

Dear Doctor:—We have received your letter of the 7th instant, and, in answer to your inquiries, beg to state that in the case you mention it may be that the child has not been inoculated with the virus of hydrophobia, although we are not positive about this, as experiments have shown that in some cases the saliva is virulent as many as six days before

the animal presents any symptoms of hydrophobia.

The fact that the little patient has suffered no inconvenience from the wound does not mean that all danger is averted, as the period of incubation varies between two weeks and one year, or more.

As for the possible treatment of the child, we would say that it might be too late to apply it, especially if the patient has been bitten on the face or hands, as a period of more than ten days has elapsed since the infliction of the bite. However, if you think it advisable to send the child here for treatment, we are willing to try our best in his behalf.

We beg to add that the person who sucked the wound has exposed herself to a great danger of infection in case the saliva be virulent and the lips and mouth of the operator be not perfectly sound at the time.

Yours truly,

NEW YORK PASTEUR INSTITUTE,
per F. T. LABADIG,
Physician in Charge.

Dr. Jacob Michaux said that there was a strong element of doubt regarding the condition of the animal before the child was bitten and as to the cause of death; also as to the existence of rabies in the neighborhood before the dog was injured. Because of the wound found on the dog's head there is a reasonable probability that meningitis caused the spasms. Of all sensational things, hydrophobia is the greatest in the popular mind. It is a mistake to have the dog killed. If a person is bitten, it is thought the mere killing prevents hydrophobia. The dog should be watched. A cause of convulsions, which should not be overlooked, is heat.

Dr. Wellford said the dog should be kept alive ten or twelve days. *Dr. Jordan* will not have any trouble with his little patient. If the child had been older, he might have trouble by mental impression or apprehension. He thought a great deal of reported rabies is hysteria. He had seen, in all his long practice, but one case of rabies satisfactorily demonstrated. Fright, fear and alarm causes death from nervous exhaustion.

He believed that keeping a patient under chloral and chloroform for five or six days would obviate their effects. In the case reported, the prompt and efficient measures instituted would have saved, even had the animal been rabid. If the dog had been eating meat at the time, there might have been danger of septic infection.

Dr. Jordan said the dog was not killed, but died. He realized the strength of mental impressions. Post-mortem examination showed no meningitis or encephalitis.

Dr. J. S. Wellford exhibited a BOLUS OF HAIR CAUSING BOWEL OBSTRUCTION AND REQUIRING LAPAROTOMY. The bolus of hair was about an inch and a half in diameter and three inches long, removed from the small intestine of a girl aged fourteen. There were appearances of beginning menstruation. Pain appeared first in the right iliac region, but soon spread over the whole abdomen, and was intense. There was no fever or increase of pulse, and bowel operations were small. *Dr. Long* was called in consultation and thought it a ruptured appendicitis. Upon operation, this bolus of hair was found completely occluding the lumen of the intestine. There was violent vomiting, which, just before the operation, became stercoraceous.

Dr. Virginius W. Harrison reported the case of a boy, aged three years, who had been in the habit of eating wall paper, and finally passed balls of it. Constant surveillance was necessary to keep him from it.

Dr. Upshur reported a case of PUERPERAL MANIA. The patient had been afflicted for six or eight years with chronic diarrhea. Previous to her marriage she had been a shirt maker. During the spasms, she passed a large ball composed of cotton threads, which it is supposed she swallowed in biting off threads to thread her needles. The interesting point here is not the obstruction, but chronic diarrhea which resulted. After recovery from mania, she was put on treatment for diarrhea and is now entirely well.

On presentation by *Dr. J. N. Upshur*,

resolutions recommending *Dr. W. F. Drewry*, now First Assistant Physician to Central State (Lunatic) Hospital, Petersburg, Va., as Superintendent of the same on the retirement of the present officer, were unanimously adopted by the Academy.

Medical Progress.

FLATULENCE AND INDIGESTION IN NURSING WOMEN.—*Dr. H. C. Anderson* of Brooklyn, N. Y., resident physician of the Brooklyn Seaside Home, has had, during the past season, unusual success in treating cases received at the Home. He has given especial attention to the poor mothers who come to spend a week at the Home with their young infants.

These women live mostly on potatoes and other starchy foods, and in consequence are frequently the victims of intestinal indigestion.

Dr. Anderson reports that taka-diastase promptly relieves the flatulence which accompanies this form of dyspepsia, and they appear to feel much more comfortable in every way.

It is one of the most important factors in the problem of infant feeding that mothers, especially among the very wealthy and the very poor, do not have a proper diet. Consequently, the milk which they secrete is deficient both in quality and quantity, and this renders it all the more difficult to treat their infants.

* * *

AMPUTATION OF THE BREAST FOR CARCINOMA.—*Dr. Tansini (Medical Record)* calls attention to the fact that many times a cancer of the breast recurs in the apparently healthy skin along the scar. To avoid this possibility, he advocates the removal of the entire skin from the breast and a strip four inches wide extending into the axilla. The author removes all glands and the pectoral muscle. To cover this defect he twists a flap from the back on a pedicle near the axilla and sews it into the wound.

MARYLAND Medical Journal.

PUBLISHED WEEKLY.

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MARYLAND MEDICAL JOURNAL,

209 Park Ave., Baltimore, Md.

WASHINGTON OFFICE:

913 F Street, N. W.

BALTIMORE, OCTOBER 31, 1896.

THE semi-annual meeting of the Medical and Chirurgical Faculty of Maryland will be held this year at Hagerstown and as the committee of arrangements have finished

their work in a very complete manner it is hoped that the profession interested will respond by a large attendance and a hearty coöperation. It will be remembered that seven years ago when it was decided to reorganize these semi-annual meetings, which in years past had been such failures, the Faculty went to the picturesque and hospitable city of Hagerstown, where the profession and citizens treated them royally, and have been most cordial in wishing a repetition of that visit. Next Tuesday week this meeting will be held. The following is the official programme, subject to such changes as may be necessary:

The Faculty will meet on Tuesday, November 10, at 2 P. M., and adjourn at 5.30 P. M., meet again at 7.30 P. M., and adjourn at 9.45 P. M.,

when a banquet and reunion will be held. On Wednesday, November 11, the meeting will be called to order at 10.30 A. M., and adjourn at pleasure.

As nearly as possible, papers will be read in the following order:

Tuesday, November 10, First Day, 2 P. M.

1. C. Birnie, Continued Fevers.
 2. J. C. Hemmeter, Concerning the Nature and Treatment of Gastric Acidity.
 3. George J. Preston, Cerebral Syphilis.
 4. J. Whitridge Williams, Malaria Complicating Gynecological Operations.
 5. Thomas Opie, Gynecological Diagnosis.
 6. Thomas A. Ashby, A Review of Some Mooted Questions in Intra-Pelvic Surgery.
 7. J. M. Hundley, Value of the Cystoscope in the Diagnosis and Treatment of Diseases of the Female Bladder.
 8. J. D. Skilling, Antitoxine in the Treatment of Laryngeal Diphtheria.
 9. J. Fussell Martenet, The Urgency of Antitoxine Therapy with Reference to Diphtheria Antitoxine.
 10. S. K. Merrick, To what extent does the Hypertrophied Pharyngeal Tonsil Atrophy at or about Puberty?
 11. George H. Rohé, Early Symptoms of Paresis.
 12. Samuel J. Fort, Manual Training for the Feeble-Minded.
 13. Hiram Woods, Jr., Acute Otitis Media and Mastoiditis with Trivial Local but Marked Constitutional Symptoms, Mastoid Operation. Recovery.
- Tuesday, 7.30 P. M.
Demonstrations.
14. William Osler, A Case of Diffuse Scleroderma; Exhibition of Patient.
 15. William H. Welch, William Osler and Simon Flexner, Pathology and Bacteriology of Typhoid Fever.
 16. Julius Friedenwald and Standish McCleary, A Case of Lymphatic Leukemia with Exhibition of Blood Specimen.
 17. William B. Canfield, Modern Methods of Examining Urinary Sediment.
 18. J. M. T. Finney and Mr. Smiles, Use of the X Rays.
- Adjournment at 9.45 P. M. for supper.
Second Day, Wednesday, November 11, 10.30 A. M.
19. J. W. Humrichouse, Some of the Results of Bacteriological Research.
 20. V. M. Reichard, A Case of Hydrophobia.

21. J. H. Hardcastle, Bowel Obstruction Simulating Appendicitis.

22. R. Percy Smith, Glycerine as a Treatment for Sciatica.

23. Frank Martin, The Various Operations for the Removal of the Tongue and adjacent Areas affected with Cancer.

24. Randolph Winslow, A Case of Gastrotomy for Esophageal Obstruction.

25. J. C. Bloodgood, A Case of Lateral Anastomosis of the Ileum and Cecum following Resection of Gangrenous Bowel ; Exhibition of Patient.

26. William S. Gardner, The Diagnosis of Retrodisplacements of the Uterus.

27. Robert T. Wilson, Treatment of Pelvic Inflammatory Conditions through Vaginal Incisions.

28. Joseph E. Gichner, The Present Status of the Treatment of Tuberculosis.

29. Edward J. Bernstein, Treatment of Wounds of the Eye and Ocular Appendages.

30. H. O. Reik, The Practical Use of Skiagraphy.

It is thus seen that the material supplied is abundant and the opportunities for discussion great. The papers will be limited to twenty minutes and the discussions must also be short in order to finish the whole programme. The attendance will probably be large, not only in remembrance of the cordial reception given at Hagerstown seven years ago, but also because the whole profession of Western Maryland has been individually invited to be present and take part in the proceedings. The demonstrations of typhoid fever will be especially interesting and the Programme Committee invites all physicians, whether members of the Faculty or not, to be present and take part in this discussion, and those having specimens of lesions bearing on this disease are cordially invited to exhibit them. The Röntgen Rays machine will probably be on exhibition during the whole session.

As for the details of arrangements, the two best hotels are the Hamilton House and the Baldwin House. Both are good and at both the rates are from \$2.00 to \$2.50, according to location. The Western Maryland Railroad will sell round-trip tickets to Hagerstown from any point on its line at two cents a mile. These tickets are issued especially for this meeting and are good from November 7 to 14. To obtain them a card for presentation to the ticket agent must first be procured from the

Corresponding Secretary, Dr. W. Guy Townsend, 10 West North Avenue, Baltimore. This reduction will make the round-trip tickets from Baltimore cost \$3.33, instead of the usual fare, \$4.50. Trains leave Hillen Station at 8.11 A. M., reaching Hagerstown at 12.15 P. M., in time for the first session. There is also a convenient train in the afternoon and returning trains may be had immediately after adjournment.

THE Book and Journal Club of the Faculty is composed of Faculty members who give five dollars a year to *The Book and Journal Club* supplement the appropriation for buying books for the library.

The opening meeting for this season was held last Wednesday night and interesting reports on medical progress were made by Drs. William Osler, L. McLane Tiffany and William H. Welch.

Dr. Osler dwelt on the medical side of progress, Dr. Tiffany took up such surgical subjects as appendicitis, renal surgery and treatment of malignant tumors with certain antagonistic organisms and Dr. Welch reviewed the newer literature on bacteriology and pathology. The new books purchased by the Club and by the Frick fund were shown and a general discussion took place.

Membership to the Book and Journal Club is open to any member of the Faculty and is bound by no stringent rules. The books thus purchased, while the property of the Club, are put on the shelves of the library and may be read by any Faculty member.

The spirit of progress which has of late shown itself in the Faculty and the library is easy to trace and the advances made in the past few years make membership to the State Faculty very desirable.

The membership Committee of the Faculty is preparing a list of eligibles and an active, systematic canvass will be made throughout the State. The Frick Library has been well furnished and will be dedicated with appropriate ceremonies in the near future. A tablet will be erected to the memory of Dr. Frick and addresses made by Drs. S. C. Chew, George W. Miltenberger and others. It is also probable that the Governor of Maryland and Mayor of Baltimore will be present and possibly other officials, as this is one of the oldest organizations in the State.

Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending October 24, 1896.

Diseases.	Cases Reported	Deaths.
Smallpox.....		
Pneumonia.....		13
Phthisis Pulmonalis.....		21
Measles.....		
Whooping Cough.....	8	2
Pseudo-membranous Croup and Diphtheria. }	20	10
Mumps.....		
Scarlet fever.....	18	1
Varioloid.....		
Varicella.....		
Typhoid fever.....	13	4

Diphtheria is said to be prevalent in St. Michaels, Talbot County, Maryland.

Russia will allow foreign Jewish physicians to attend the Twelfth International Medical Congress at Moscow.

The Book and Journal Club met last Wednesday night at the Faculty's Building and reported on new literature received.

St. Luke's Hospital of New York is having trouble in giving a clear title to the property not long ago vacated on Fifth Avenue.

Dr. Talcott Eliason of Hancock, Maryland, died last week. Dr. Eliason was graduated from Jefferson Medical College in 1847.

According to reports, the Colorado Board of Health advises that the great army of invalids who regularly come to that State be excluded.

The Hebrew Hospital and Asylum of Baltimore has received \$300 from the estate of Mrs. Henrietta Bergman, widow of Philip Bergman, of that city.

An enterprising company for insuring impaired risks is offering physicians commissions for the recommendation of cases which want insurance.

Dr. William H. Baltzell, who has spent some time abroad in studying, has returned to Baltimore and will open an office at 604 North Charles Street.

The Police Department of Baltimore suggests the use of a bicycle ambulance. Hos-

pitals that receive city or State aid should be compelled to use ambulances.

A New York physician has been sued by an undertaker, who is also a coroner, for calling cases of smallpox chickenpox, thus exposing the coroner-undertaker to smallpox, which he contracted.

The New York State Board of Health complains that its powers are too limited and the annual appropriation of \$200,000 too small. The Maryland State Board of Health has an annual appropriation of about \$5000.

Dr. A. C. Abbott, formerly connected with the Johns Hopkins Hospital, but now Professor of Hygiene at the University of Pennsylvania, is giving a series of lectures on his specialty to the Johns Hopkins medical students.

The Maryland General Hospital has succeeded in obtaining Miss Annie Murrey as head of the nurses' training school of that hospital. Miss Murrey is a graduate of the Edinburgh Royal Infirmary and has held responsible positions in this country.

Dr. Thomas C. Price, a prominent physician of Frostburg, Maryland, was instantly killed by a freight train as he was crossing the tracks. Dr. Price was a graduate of the University of Maryland in 1852 and was a brother of Dr. A. B. Price of the same place.

Dr. Frank Donaldson, formerly of Baltimore, and whose father was so well-known here for years, has been made Professor of Physiology in the new College of Physicians and Surgeons of San Francisco, of which Dr. Winslow Anderson, formerly editor of the *Pacific Medical Journal* of that city, is dean.

For the next meeting of the Clinical Society of Maryland, to be held Friday, November 6, the following programme is announced:

Amoebic Obstruction of the Liver Perforating the Inferior Vena Cava. Dr. Simon Flexner. Discussion to be opened by Dr. Osler.

Etiology of Infantile Convulsions. Dr. F. D. Sanger. Discussion to be opened by Dr. C. W. Mitchell.

Report of a Case of Symphysiotomy. Dr. T. A. Ashby. Discussion to be opened by Dr. K. B. Batchelor.

Report of a Case of Osteoma of the Auditory Canal. Dr. Harry Friedenwald. Discussion to be opened by Dr. Herbert Harlan.

Book Reviews.

CATALOGUE OF THE BAUSCH & LOMB OPTICAL COMPANY. Rochester and New York City. 1896. Fifteenth Edition.

This is an exceedingly valuable collection of information on microscopes and other instruments of precision, including microtomes, photo-micrographs and laboratory apparatus. The illustrations are abundant and the volume, showing the extensive facilities of the company, is well worth an examination.

ANNOUNCEMENT OF THE ALMA SANITARIUM, Alma, Michigan. Illustrated.

The situation of the Alma Sanitarium and its wonderful facilities make it a place worthy of consideration when sanitarium treatment is under advisement. Dr. E. S. Pettyjohn is the resident physician and a large staff of consultants from Detroit, Chicago and other places also give their services.

THE editors of Mathews' Medical Quarterly announce that with the January issue of that publication its name will be changed to *Mathews' Quarterly Journal of Rectal and Gastro-Intestinal Diseases*. This is a change which has been deemed necessary for some time, as it is essential that the title of a medical journal should convey to the reader an idea of its contents and this has not been the case with its name from the beginning. There will be no change in the policy of the journal in the least. As it will continue to be the only English publication devoted to diseases and surgery of the rectum and gastro-intestinal tract, the articles which will appear in it will be limited to these subjects. The journal will continue to be edited by Drs. J. M. Mathews and Henry E. Tuley and published in Louisville, Kentucky.

REPRINTS, ETC., RECEIVED.

Inguinal and Scrotal Cysts, Simple and Complicated, in Infants or Young Children. By Thomas H. Manley, M. D. Reprint from the *American Medico-Surgical Bulletin*.

Some Remarks about Asepsis in Military Service. By Lieutenant-Colonel Edward Boeckmann, Assistant Surgeon-General Minnesota National Guard. Reprint from the Proceedings of the Fifth Annual Meeting of the Military Surgeons of the United States.

Current Editorial Comment.

LIFE INSURANCE EXAMINER.

Medical Examiner.

A PHYSICIAN who desires to do the best work as an examiner or as a medical director needs more than scientific training. That is a prerequisite, of course, but he also needs a worldly training, which can only be had outside of his study. He should mingle with men, he should not hesitate to take an active part in all honorable effort as he has an opportunity to do so. He should above all things devote considerable time to travel, not alone in foreign countries, but over the field in which his company proposes to do business.

DRUGGISTS' PRESCRIBING.

American Medico-Surgical Bulletin.

WE would be pleased to see the pharmaceutical journals, of which there are many excellent ones, take up this question and teach the offenders in the craft the difference between right and wrong. Many druggists grumble because many physicians are in the habit of prescribing and dispensing medicines. This course will become the necessary one with physicians who are desirous of practicing from a scientific standpoint, if it be found that, in communities where there exists no law forbidding the druggist to prescribe, he is overstepping his province, which is simply that of compounding and dispensing, and nothing more.

SCIENTIFIC PROGRESS.

Medical World.

ALL that is now known of medical science is but as a child's primer compared with what the world will some time know. But even what we now possess of medical knowledge comes to us not as a result of our own merit, our personal investigations and achievements; it comes as an inheritance from past ages, and represents the result of countless theories advanced, the vast majority of which prove to be erroneous and are now forgotten, while the precious few finally remained to take their place as permanent steps in scientific progress. Who can tell the innumerable mistakes and discarded errors that mark the line of march of medical science? Yet each one of these mistakes was thought by its originator to be a scientific truth, perhaps of great value.

Publishers' Department.

Convention Calendar.

NOVEMBER						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	...	...	...	...	...

DECEMBER						
S	M	T	W	T	F	S
...	...	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	...	...

State Societies.

NOVEMBER.

- 10-11. MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, at Hagerstown.
 27. NEW YORK STATE ASSOCIATION OF RAILWAY SURGEONS, at New York City. C. B. Henich, M. D., Secretary, Troy.

National Societies.

NOVEMBER.

10. SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION, at Nashville. W. E. B. Davis, M. D., Secretary, Birmingham, Ala.
 16-19. PAN-AMERICAN MEDICAL CONGRESS, at City of Mexico, Mexico.

DECEMBER.

- 30-31. WESTERN SURGICAL AND GYNECOLOGICAL ASSOCIATION. Herman E. Pearse, M. D., Secretary, Kansas City, Mo.

BALTIMORE.

- BALTIMORE MEDICAL ASSOCIATION, 847 N. Eutaw St. Meets 2d and 4th Mondays of each month.
 BOOK AND JOURNAL CLUB OF THE FACULTY. Meets 2d and 4th Wednesdays, 8 P. M.
 CLINICAL SOCIETY, 847 N. Eutaw St. Meets 1st and 3d Fridays—October to June—8.30 P. M. S. K. MERRICK, M. D., President. H. O. REIK, M. D., Secretary.
 GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE, 847 N. Eutaw St. Meets 2d Tuesday of each month—October to May (inclusive)—8.30 P. M. W. S. GARDNER, M. D., President. J. M. HUNDLEY, M. D., Secretary.
 MEDICAL AND SURGICAL SOCIETY OF BALTIMORE, 847 N. Eutaw St. Meets 2d and 4th Thursdays of each month—October to June—8.30 P. M. W. S. GARDNER, M. D., President. CHAS. F. BLAKE, M. D., Corresponding Secretary.
 MEDICAL JOURNAL CLUB. Every other Saturday, 8 P. M. 847 N. Eutaw St.
 THE JOHNS HOPKINS HOSPITAL HISTORICAL CLUB. Meets 2d and 4th Mondays of each month at 8 P. M.
 THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY. Meets 1st and 3d Mondays, 8 P. M.
 THE JOHNS HOPKINS HOSPITAL JOURNAL CLUB. Meets 2d Friday and 4th Monday, at 8.15 P. M.
 MEDICAL SOCIETY OF WOMAN'S MEDICAL COLLEGE. SUE RADCLIFF, M. D., President. LOUISE ERICH, M. D., Corresponding Secretary. Meets 1st Tuesday in the Month.
 UNIVERSITY OF MARYLAND MEDICAL SOCIETY. Meets 3d Tuesday in each month. 8.30 P. M. HIRAM WOODS, JR., M. D., President. E. E. GIBBONS, M. D., Secretary.

WASHINGTON.

CLINICO-PATHOLOGICAL SOCIETY. Meets at members' houses, 1st and 3d Tuesdays in each month. HENRY B. DEALE, M. D., President. R. M. ELLYSON, M. D., Corresponding Secretary. R. H. HOLDEN, M. D., Recording Secretary.

MEDICAL AND SURGICAL SOCIETY OF THE DISTRICT OF COLUMBIA. Meets 2d Monday each month at members' offices. FRANCIS B. BISHOP, M. D., President. LLEWELLYN ELIOT, M. D., Secretary and Treasurer.

MEDICAL ASSOCIATION OF THE DISTRICT OF COLUMBIA. Meets Georgetown University Law Building 1st Tuesday in April and October. W. P. CARR, M. D., President. J. R. WELLINGTON, M. D., Secretary.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA. Meets Wednesday, 8 P. M. Georgetown University Law Building. S. C. BUSBY, M. D., President. S. S. ADAMS, M. D., Recording Secretary.

WOMAN'S CLINIC. Meets at 1833 14th Street, N. W., bi-monthly. 1st Saturday Evenings. MRS. M. H. ANDERSON, 1st Vice-President. MRS. MARY F. CASE, Secretary.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY. Meets 1st and 3d Fridays of each month at members' offices. GEORGE BYRD HARRISON, M. D., President. W. S. BOWEN, M. D., Corresponding Secretary.

PHARMACEUTICAL.

TETANUS.—Four cases of traumatic tetanus, under treatment at the Cook County Hospital at the same time, make a remarkable record in the treatment of this fatal malady. Three out of the four recovered, while the one that died was prognosed most favorable of the quartet on admission to the hospital. The first case was in the service of Dr. A. F. Lemke. The patient was a boy of 17 years who stepped upon a nail and received a puncture in the sole of the right foot. He was admitted to the Hospital on the 20th day of September, 1896, and had general tetanus of the most pronounced type. On the 22nd he was given 50 cubic centimeters of the Pasteur Vaccine Company's Tetanus Antitoxine, which was followed by a decided amelioration of the symptoms. On the 23rd he was given 20 cubic centimeters more, and on the 29th a third dose of 20 cubic centimeters. This was the last dose of the Antitoxine used and his recovery was uninterrupted. The other three cases were in the service of Dr. L. Dysart, furnishing interesting records, who kindly furnished the notes herewith given. The first patient was a colored boy of 14 years. The trismus in this case was well marked and accompanied by some *risus sardonicus*. The convalescence was established and the patient was practically well a little more than three weeks from the date of the attack.

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DIURETIN is a pure diuretic, and acts by stimulation of the renal cells and renal parenchyma, increasing the flow of urine even in those cases in which the heart muscle no longer responds to the usual cardiac remedies.

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It is frequently very active even where digitalis, strophanthus, etc., have failed.

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MEDICAL PROPERTIES.—The preparation is entitled to rank as one of the most valuable therapeutical agents in *quieting non-inflammatory excitement of the Reflex Centers of the Cord, of the Peripheral Afferent Nerves, of the Genital Function and of the Cerebrum.* It is particularly valuable in *Epilepsy*, nearly always effecting a permanent cure where the cause is idiopathic, and the patient follows up the treatment closely. In many forms of *Puerperal, Infantile, and Hysterical Convulsions*, the most happy results follow its use. The **ELIXIR SIX BROMIDES** cannot be overrated in relieving *Nervous Headache, Sleeplessness, Neurasthenia, General Nervous Irritation*, and the various *Functional Disorders*. As a direct means of *diminishing the frequency of Seminal Emissions* it is of great service. We claim that the **ELIXIR SIX BROMIDES** is much **LESS DEPRESSANT** to the CIRCULATION than if a lesser number of the Bromides were administered; also the Iron it contains gives it the great advantage of not being FOLLOWED—even if its use is LONG CONTINUED—by the SEVERE ANEMIA that so often follows the use of the Bromides given alone. Physicians when prescribing will please write: *Bromidi Elix. Sex.*—One bottle, (WALKER-G's.) Druggist will write directions on his own label. Attention is also called to our **ELIXIR SIX IODIDES, ELIXIR SIX HYPOPHOSPHITES, ELIXIR SIX APERIENS**, which are unexcelled for clinical efficiency and palatability.

A liberal discount will be allowed Physicians who desire to prove their clinical efficiency. Wholesale price per dozen: Iodides, \$8.00; Hypophosphites, \$8.00; Bromides, \$8.00; Aperiens, \$8.00.

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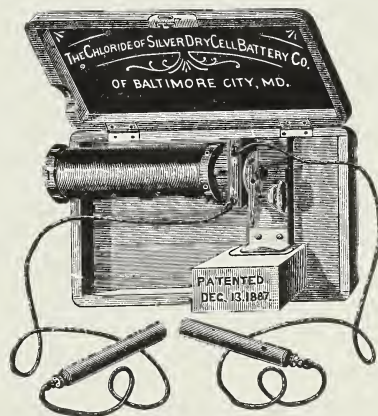
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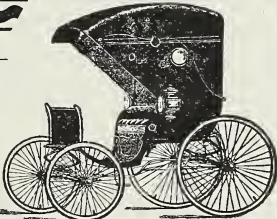
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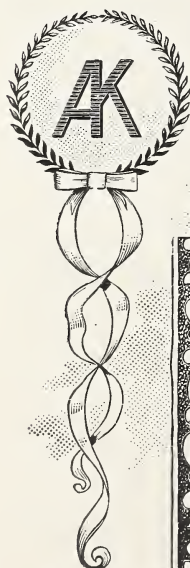
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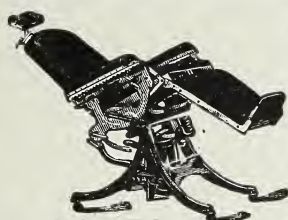


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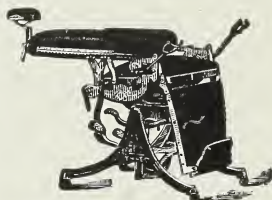


Fig. XVII—Dorsal Position.

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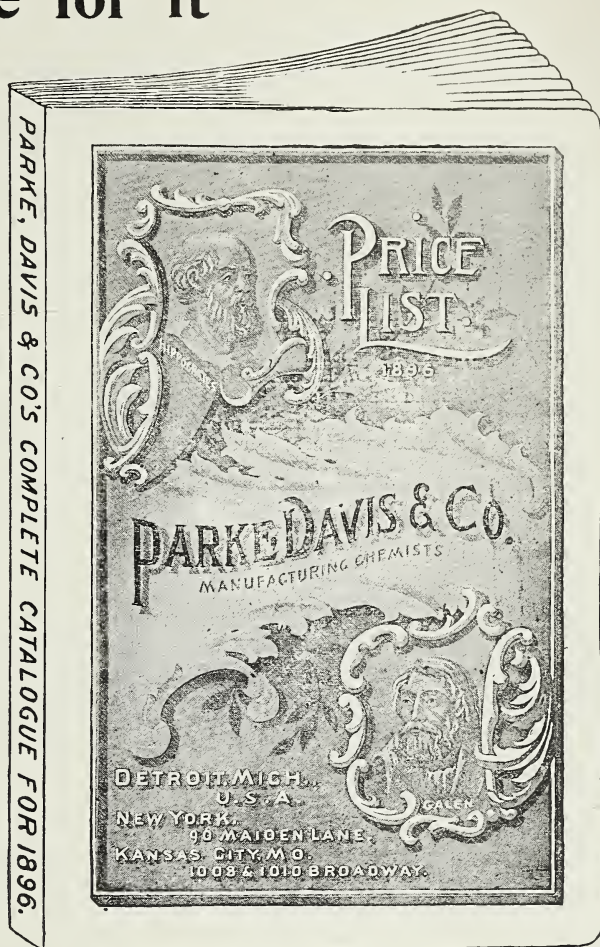
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